

10180

## CERTIFICATE OF DEATH

Reg. Dist. No.

10160

1. PLACE OF DEATH a. COUNTY <u>Charles</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Charles</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>La Plata</u>		c. LENGTH OF STAY IN 1b <u>3 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Physicians Memorial Hosp.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>JAMES RICHARD Coates</u>		4. DATE OF DEATH Month Day Year <u>Sept 22, 1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 20, 1936</u>
9. AGE (In years last birthday) <u>23</u>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Hotel</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Wilson T. Coates</u>		14. MOTHER'S MAIDEN NAME <u>Mary Ann Coates</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u> INFORMANT Address <u>Mary Ann Toye, Hughesville, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fracture - Dislocation of 6<sup>th</sup></u> <u>823X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <u>Cervical Vertebra &amp; Transection</u> DUE TO (c) <u>of Spinal Cord.</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>3 DAYS</u> INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Automobile Accident Sept 19/59 (Car off road)</u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office, etc.) <u>23 Church Road</u>		20f. (City or town) (County) (State) <u>Charles Md.</u>	
21. I certify that I attended the deceased from <u>Sept 19, 1959</u> , to <u>Sept 21, 1959</u> , that I last saw the deceased alive on <u>Sept 21, 1959</u> , and that death occurred at <u>10:30 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>J. PARRAN JARBOE</u> M.D.		DATE SIGNED <u>9-22-59</u>	
PHYSICIAN'S NAME (Type) <u>J. PARRAN JARBOE</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9-24-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St Marys</u>		22d. LOCATION (City, town, or county) (State) <u>Bryantown, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The Shunt Funeral Home, Wilder, Md.</u> ADDRESS		24a. REC'D BY REGISTRAR <u>SEP 25 '59</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur &amp; Hays</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

State of New York  
County of ...  
I, the undersigned, a Justice of the Peace for the County of ... do hereby certify that on the ... day of ... 1910, at ...  
the following named person died:  
Name of Deceased ...  
Age ...  
Sex ...  
Color ...  
Married ...  
Occupation ...  
Cause of Death ...  
Place of Death ...  
Signature of Physician ...  
Signature of Minister of the Gospel ...  
Signature of Justice of the Peace ...  
Witnessed by me, the undersigned, on the ... day of ... 1910, at ...

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10161

Reg. Dist. No.

10181

1. PLACE OF DEATH a. COUNTY <i>Charles</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <i>DC</i> b. COUNTY <i>Washington</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>La Plata</i>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Phy Mem Hosp</i>				d. STREET ADDRESS <i>614 Orleans Pl NE</i>			
3. NAME OF DECEASED (Type or print) First Middle Last <i>ROBERT MORRIS DIGGS</i>				4. DATE OF DEATH Month Day Year <i>SEPT 29 1959</i>			
5. SEX <i>M</i>	6. COLOR OR RACE <i>N</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>April 5 1903</i>	9. AGE (In years last birthday) <i>56</i> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Truck Driver</i>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Washington DC</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>
13. FATHER'S NAME <i>Isaac Johnson</i>				14. MOTHER'S MAIDEN NAME <i>Mary Johnson</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Ernest Diggs</i>		Address <i>Washington DC</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Ruptured Liver</i> 823X and DUE TO (b) <i>Bilateral Hemothorax</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <i>Multiple Rib Fractures</i>							INTERVAL BETWEEN ONSET AND DEATH <i>46 h.</i> <i>46 h.</i> <i>46 h.</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Secondary Hemorrhage</i>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Passenger-auto accident-Potomac River Bridge</i>					
20c. TIME OF INJURY Month, Day, Year <i>12 noon 9-27 1959</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Rt. 301</i>	20f. (City or town) (County) (State) <i>NEWBERG, CHARLES, MD.</i>				
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <i>V.B. Dettor</i>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <i>V.B. DETTOR</i>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>10-3-59</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Lincoln</i>		22d. LOCATION (City, town, or county) (State) <i>and</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>W.D. Bacon</i>				ADDRESS <i>1722 74th St NE</i>		24a. REC'D BY REGISTRAR <i>2 OCT 2 59</i>	
				24b. REGISTRAR'S SIGNATURE <i>Arthur A. Hines</i>			

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1918

Name of Deceased		Sex		Age		Date of Death	
Place of Birth		Usual Residence		Cause of Death		Manner of Death	
Occupation		Education		Medical History		Post-mortem Examination	
Family History		Social History		Clinical History		Gross Findings	
Microscopic Findings		Bacteriological Findings		Toxicological Findings		Other Findings	
Signature of Examiner		Signature of Coroner		Signature of Physician		Signature of Witness	
Date of Certificate		Place of Death		City		County	
State		Zip		Telephone		Hospital	
Funeral Home		Burial Place		Crematorium		Other	

10182

## CERTIFICATE OF DEATH

Reg. Dist. No.

10162

1. PLACE OF DEATH a. COUNTY <u>Charles</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Charles</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bryantown</u>		c. LENGTH OF STAY IN 1b <u>Life</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Bryantown</u>	
		d. STREET ADDRESS <u>1</u>	
3. NAME OF DECEASED (Type or print) <u>Elizabeth Gill Bowling Forbes Edelen</u>		4. DATE OF DEATH <u>Sept 26 1959</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 17 1875</u>
9. AGE (In years last birthday) <u>84</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George Forbes Edelen</u>		14. MOTHER'S MAIDEN NAME <u>Frances Bowling</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>Edward G. Edelen</u>		Address <u>Bryantown, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY THROMBOSIS</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>ESSENTIAL HYPERTENSION</u> DUE TO (c) <u>GENERALIZED ARTERIO SCLEROSIS</u>			INTERVAL BETWEEN ONSET AND DEATH <u>12 DAYS</u> <u>20 YEARS</u> <u>20 YEARS</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>SEPTEMBER, 1947</u> , to <u>SEPT. 26, 1959</u> , that I last saw the deceased alive on <u>SEPTEMBER 26, 1959</u> , and that death occurred at <u>4:45 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John H. Griffin</u>		ADDRESS (Street, city or town, state) <u>Box 65, Hughesville, Md.</u>	
PHYSICIAN'S NAME (Type) <u>JOHN H. GRIFFIN</u>		DATE SIGNED <u>9-27-59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>9-30-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St Marys</u>	22d. LOCATION (City, town, or county) (State) <u>Bryantown, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>The Hunt Funeral Home, Uddys, Md.</u>		ADDRESS <u>Box 65, Hughesville, Md.</u>	
24a. REC'D BY REGISTRAR <u>DATE OCT 1 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur A. Thomas</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



10183

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Charles</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) o. STATE <u>MD</u> b. COUNTY <u>Charles</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>La Plata</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Indian Head</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Physicians Mem. Hospital</u>		d. STREET ADDRESS <u>45 - Mattingley Ave.</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>HENRY SMITH ELSEBOUGH</u>		4. DATE OF DEATH Month Day Year <u>SEPT. 14 1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb 12 1875</u>
9. AGE (In years last birthday) yrs. <u>84</u>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Book Keeper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Bookkeeping Long Island N.Y.</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Elsebough</u>		14. MOTHER'S MAIDEN NAME <u>Catherine Welch</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>080-099468</u> INFORMANT Address <u>L. Kiernan Indian Head.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>434.4 Acute Cardiac Dilatation</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Chronic cardiac failure</u> (c) <u>6 months</u>			INTERVAL BETWEEN ONSET AND DEATH <u>6 months</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>9-14</u> , 19 <u>59</u> , to <u>9-14</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>9-14</u> , 19 <u>59</u> , and that death occurred at <u>9:00</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>[Signature]</u> M.D.		ADDRESS (Street, city or town, state) <u>La Plata, Md.</u> DATE SIGNED <u>9-14-59</u>	
PHYSICIAN'S NAME (Type) <u>[Signature]</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>9/18/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Eugene's</u>	22d. LOCATION (City, town, or county) (State) <u>Long Island N.Y.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u> ADDRESS <u>La Plata Md</u>		24a. REC'D BY REGISTRAR <u>SEP 21 '59</u>	24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

10108

CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18									
Item 9 Film G249 10/2/59 iwk									
10184									
CERTIFICATE OF DEATH									
Reg. Dist. No. 10168									
1. PLACE OF DEATH a. COUNTY Charles MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Charles				
b. CITY-OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cobb Island					c. LENGTH OF STAY IN lb				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Cobb Island				
d. STREET ADDRESS 1					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First Middle Last JEANNETTE B HOUGH					4. DATE OF DEATH Month Day Year SEPT 24 1959				
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 8, 1887 72 yrs.		9. AGE (In years last birthday) yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) H W		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Md		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Hyram Gibbons					14. MOTHER'S MAIDEN NAME Elizabeth Dougherty				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No					16. SOCIAL SECURITY NO. INFORMANT Mrs Ralph Black London Md.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 241X Bronchial asthma									
Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) Chronic asthmatic condition									
(c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)					20f. (City or town) (County) (State)				
21. I certify that I attended the deceased from June 1957, to Sept 24, 1959, that I last saw the deceased alive on Sept 15, 1959, and that death occurred at 2:00 P. M. from the causes and on the date stated above.									
ACTUAL SIGNATURE F. M. Johnson M.D.					ADDRESS (Street, city or town, state) La Plata Md DATE SIGNED 9-24-59				
PHYSICIAN'S NAME (Type) F. M. JOHNSON									
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 9-26-59		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill		22d. LOCATION (City, town, or county) (State) Suitland Md			
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS					24a. REC'D BY REGISTRAR DATE SEP 29 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Thomas		

10101

WESTLAND STATE WILDLIFE DIVISION - JACKSON, MI

CERTIFICATE OF SALE

10184

For the year

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## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Charles</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Charles</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>La Plata</b>				c. LENGTH OF STAY IN 1b <b>X</b> <b>La Plata</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Physicans Memorial Hospital</b>				e. STREET ADDRESS <b>1</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>RUTH</b> Middle <b>HALL</b> Last <b>MALLORY</b>				4. DATE OF DEATH Month <b>SEPT</b> Day <b>7</b> Year <b>1957</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>August 7, 1874</b>		9. AGE (In years last birthday) <b>85</b> yrs.	IF UNDER 1 YEAR Months <b>85</b> Days <b>85</b> Hours <b>85</b> Min.	IF UNDER 24 HRS. Months <b>85</b> Days <b>85</b> Hours <b>85</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Wife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>		11. BIRTHPLACE (State or foreign country) <b>Milford, Kansas</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Edward Bartell</b>				14. MOTHER'S MAIDEN NAME <b>Louisa M. La Gross</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		INFORMANT Address <b>Mrs. C.J. Gridley - La Plata, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>693.4</b> DUE TO <b>Respiratory Failure</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Cellulitis of rt leg.</b> DUE TO <b>1 week</b> (c) <b>bed sores</b> DUE TO <b>2 weeks</b>							INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Fractured hip in middle of May - had nail inserted</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <b>Fell down at home</b>					
20c. TIME OF INJURY Month <b>May</b> Day <b>1957</b> Year <b>1957</b> Hour <b>o. m.</b> p. m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> of work <input type="checkbox"/> of work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>home</b>	20f. (City or town) <b>La Plata</b>	(County) <b>Charles, Md.</b>	(State) <b>Md.</b>		
21. I certify that I attended the deceased from <b>May</b> , 19 <b>57</b> , to <b>Sept</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>Sept 6</b> , 19 <b>57</b> , and that death occurred at <b>9:30 PM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>W. J. Johnson</b>				DATE SIGNED <b>9-7-57</b>			
PHYSICIAN'S NAME (Type) <b>W. J. Johnson</b>				ADDRESS (Street, city or town, state) <b>La Plata, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>9/10/1957</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Fairview Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Apache Oklahoma</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>AREHART FUNERAL HOME, INC. - La Plata, Maryland</b>				24a. REC'D BY REGISTRAR <b>SEP 11 '57</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur E. Hines</b>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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CERTIFICATE OF DEATH

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## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Charles</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Charles</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>La Plata</u>		c. LENGTH OF STAY IN 1b <u>Life</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x La Plata</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Physicians Memorial</u>				d. STREET ADDRESS <u>1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>DAISY</u> Middle <u>McPHERSON</u> Last <u>McPHERSON</u>				4. DATE OF DEATH Month <u>Sept</u> Day <u>26</u> Year <u>1959</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 12, 1902</u>	9. AGE (In years last birthday) <u>57</u> yrs.	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Frank McPherson</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Norris</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>None</u>		INFORMANT Address <u>Katie Cager, La Plata, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular hemorrhage</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arteriosclerotic Hypertension</u> DUE TO (c) <u>  </u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Sept</u> , 19 <u>56</u> to <u>Sept</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Sept 26</u> , 19 <u>59</u> , and that death occurred at <u>11 A.</u> M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>FM Johnson</u>		M.D. <u>La Plata, Md.</u>		DATE SIGNED <u>9-28-59</u>		ADDRESS (Street, city or town, state)	
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10-1-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Sacred Heart</u>		22d. LOCATION (City, town, or county) (State) <u>La Plata, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The Skunk Funeral Home, Waldorf, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>OCT 2 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur G. Knaus</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

CERTIFICATE OF DEATH

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

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10166 Items 7, 13, 14 Film G250 10-19-59 et

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>CHARLES</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Washington</b> b. COUNTY <b>Dc</b> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Newburg</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>47x-3</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS <b>911 M St N.W.</b>	
3. NAME OF DECEASED (Type or print) <b>ADA</b> First <b>VALERIE</b> Middle <b>MITCHELL</b> Last		4. DATE OF DEATH <b>SEPT. 27</b> Month <b>1959</b> Day Year	
5. SEX <b>F</b>	6. COLOR OR RACE <b>N</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept 10, 1909</b>
9. AGE (In years last birthday) <b>50</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Signor</b>	
11. BIRTHPLACE (State or foreign country) <b>Fayetteville N.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Wloyds Mc Croy</b> Address <b>911 MSP 7.W</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Traumatic Subarachnoid Hemorrhage</b> <b>823X</b> Conditions, if any, which gave rise to immediate cause (b) <b>and Crush Injuries of Chest</b> (a), stating the underlying cause lost. (c) <b>DUE TO</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 hrs.</b> <b>1 hrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>none</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Passenger auto accident - struck shuttment</b>	
20c. TIME OF INJURY Month, Day, Year <b>12:00 AM Jan 9-21 1959</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>U.S. 301</b>		20f. (City or town) <b>NEWBURG, CHARLES, MD.</b> (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>V.B. DETTOR</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>V.B. DETTOR</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>10-5-59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn</b>		22d. LOCATION (City, town, or county) <b>Wash, D.C.</b> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. B. Baker</b> ADDRESS <b>1122 7th St. N.W.</b>		24a. REC'D BY REGISTRAR <b>OCT 2 '59</b> DATE	
		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>	



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registror prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10167

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## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>CHARLES</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Charles</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rock Point</b>		c. LENGTH OF STAY IN 1b <b>Appr. 60 yrs</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Luther Arnold PRICE</b>		4. DATE OF DEATH <b>sept 24 19 59</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JAN 22 1874</b>
9. AGE (In years last birthday) <b>85</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Boat Builder</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Waterman</b>	
11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S. A.</b>	
13. FATHER'S NAME <b>Martin Luther Price</b>		14. MOTHER'S MAIDEN NAME <b>Lucy Ashton</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>NONE</b>	
17. INFORMANT <b>Mary M. GONONG, Alex, Va.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.0</b> DUE TO <b>Cranial occlusion</b> Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) <b>Arteriosclerotic heart disease</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>minutes</b> <b>1 year.</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Basal cell carcinoma face.</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>9 Jan</b> , 19 <b>51</b> , to <b>10 Aug</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>24 September</b> , 19 <b>59</b> , and that death occurred at <b>6: AM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Arwooddy</b>		ADDRESS (Street, city or town, state) <b>La Plata. Md.</b> DATE SIGNED <b>25 Sept 59</b>	
PHYSICIAN'S NAME (Type) <b>Arthur O. Wooddy, M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9-26-59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Holy Ghost</b>		22d. LOCATION (City, town, or county) (State) <b>Issue, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>The Hunt Funeral Home, Waldorf, Md.</b>		24a. REC'D BY REGISTRAR <b>SEP 30 '59</b>	
ADDRESS		24b. REGISTRAR'S SIGNATURE <b>Arthur A. K...</b>	



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10169

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Charles</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>Charles</i>	
b. CITY OR TOWN (If within corporate limits, write RURAL and give nearest town) <i>La Plata</i>		c. LENGTH OF STAY IN 1b <i>20 min</i>	
3. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Physicians Memorial Hosp.</i>		d. STREET ADDRESS <i>Pisgah</i>	
3. NAME OF DECEASED (Type or print) <i>AGNES</i> First <i>YVONNE</i> Middle <i>PROCTOR</i> Last		4. DATE OF DEATH <i>SEPT. 15</i> 19 <i>59</i> Year	
5. SEX <i>F</i>	6. COLOR OR RACE <i>N</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>NOV 13 1937</i>
9. AGE (In years last birthday) <i>21</i> yrs.		IF UNDER 1 YEAR	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>	11. BIRTHPLACE (State or foreign country) <i>Maryland</i>
12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>		13. FATHER'S NAME <i>George C. Gray</i>	
14. MOTHER'S MAIDEN NAME <i>Annie Butler</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>NO</i> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <i>218-34-7045</i>		17. INFORMANT <i>John Proctor, Pisgah, Md.</i> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Shock and hemorrhage</i> DUE TO <i>825X</i> Conditions, if any, which gave rise to immediate cause (b) <i>Rupture of Pregnant uterus</i> DUE TO <i>1483</i> cause lost. (c) <i>None</i>			INTERVAL BETWEEN ONSET AND DEATH <i>30 min.</i> <i>30 min.</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>1483</i>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Auto accident - Route 301 and 6</i>	
20c. TIME OF INJURY Month, Day, Year <i>9-15 19 59</i> Hour <i>0745</i> m. <i>5</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Highway</i>	20f. (City or town) <i>La Plata, Charles, Md.</i> (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>V.B. Dettor</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <i>V.B. DETTOR</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>9-19-59</i>	22c. NAME OF CEMETERY OR CREMATORY <i>St Catherine</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>The Hunt Funeral Home, Waldorf, Md.</i>		22d. LOCATION (City, town, or county) <i>Mc Conchie, Md.</i> (State)	
24a. REC'D BY REGISTRAR <i>SEP 22 '59</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur L. Frank</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10170

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>CHARLES</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>NY</b> b. COUNTY <b>NASSAU</b> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>LA PLATA</b>		c. LENGTH OF STAY IN 1b <b>2 1/2 hrs.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>PHYSICIAN'S MEMORIAL HOSPITAL</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Seaford - Long Island</b>	
3. NAME OF DECEASED (Type or print) <b>Frances</b> First Middle Last <b>Rosen</b>		4. DATE OF DEATH <b>SEPTEMBER 15 1959</b> Month Day Year	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W.</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4-9-1914</b>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Nurse</b>		9b. AGE (In years last birthday) <b>45</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Nurse</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>—</b>	
11. BIRTHPLACE (State or foreign country) <b>Poland</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>	
13. FATHER'S NAME <b>Joseph Osman</b>		14. MOTHER'S MAIDEN NAME <b>Becky Zepnick</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>yes - unknown</b>	
17. INFORMANT <b>Benjamin Rosen - Seaford, L.I. N.Y.</b>		Address <b>Seaford, L.I. N.Y.</b>	
18. CAUSE OF DEATH (Enter only one cause pertaining to (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Shock and Hemorrhage</b> 825X DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Crush injuries of chest</b> (c) <b>Crush injuries of chest</b> DUE TO underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH <b>2 h. 45 min.</b> <b>2 h. 45 min.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Scleroderma</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Auto Highway accident - Rt. 301 and 6</b>	
20c. TIME OF INJURY Month, Day, Year <b>7:30 a.m. 9-15-59</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Highway</b>		20f. (City or town) <b>LA PLATA CHARLES, MD.</b> (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>V.B. Dettor</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>V.B. DETTOR, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <b>9-15-59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9/17/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Beth Davis Cem.</b>		22d. LOCATION (City, town, or county) <b>Long Island, NY</b> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>B. Danzonsky</b>		24a. REC'D BY REGISTRAR <b>SEP 16 '59</b>	
ADDRESS <b>3501 14th St NW</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur E. Kline</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

*[Faint, mostly illegible handwritten text and printed form fields. Visible fragments include:]*

NAME OF DECEASED  
AGE  
SEX  
DATE OF DEATH  
PLACE OF DEATH  
CAUSE OF DEATH  
MANNER OF DEATH  
SIGNATURE OF EXAMINER  
DATE

*[Faint circular seal or stamp is visible in the center of the form.]*

2

*[Vertical text on the right margin, mostly illegible.]*

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 10118 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10171

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Charles</u> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Waldorf</u> c. LENGTH OF STAY IN 1b <u>Life</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) _____		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If Institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Charles</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Waldorf Rural</u> d. STREET ADDRESS _____		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <u>PHILLIP Edward SEMBLY</u>			<b>4. DATE OF DEATH</b> Month Day Year <u>SEPTEMBER 1 1959</u>		
<b>5. SEX</b> <u>MALE</u>	<b>6. COLOR OR RACE</b> <u>NEGRO</u>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>1927</u>	<b>9. AGE</b> (In years last birthday) <u>31</u> yrs.	<b>IF UNDER 1 YEAR</b> Months Days Hours Min.
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Farming</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Maryland</u>	
<b>13. FATHER'S NAME</b> <u>Richard Sembly</u>			<b>14. MOTHER'S MAIDEN NAME</b> <u>Ella Browner</u>		
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) _____		<b>16. SOCIAL SECURITY NO.</b> <u>None</u>		<b>17. INFORMANT</b> <u>Portia L. Ware, 121 Quincy Pl. N.E., Washington 2, D.C.</u>	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> 420.1 DUE TO <u>Generalized Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>					
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
<b>20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH: <input checked="" type="checkbox"/></b> <u>None</u>					
<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <u>Collapsed while walking to house</u>					
<b>20c. TIME OF INJURY</b> Month, Day, Year <u>9:30 PM 9-1 1959</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>Home</u>	
<b>20f. (City or town)</b> <u>Waldorf</u>		<b>(County)</b> <u>Charles</u>		<b>(State)</b> <u>MD.</u>	
<b>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from:</b> Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
<b>ACTUAL SIGNATURE</b> <u>V.B. Dettor</u>			<b>DATE SIGNED</b> <u>9-1-59</u>		
<b>EXAMINER'S NAME (Type)</b> <u>V.B. DETTOR</u>			<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>		
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>		<b>22b. DATE THEREOF</b> <u>9-5-59</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>St Marys</u>	
<b>22d. LOCATION</b> (City, town, or county) <u>Bryantown</u>		<b>(State)</b> <u>MD.</u>			
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>The Rural Funeral Home, Waldorf, Md.</u>			<b>24a. REC'D BY REGISTRAR</b> <u>SEP 8 '59</u>		
<b>24b. REGISTRAR'S SIGNATURE</b> <u>Charles L. Hume</u>					

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



10191

## CERTIFICATE OF DEATH

Reg. Dist. No.

10172

1. PLACE OF DEATH a. COUNTY <b>Charles</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Charles</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>La Plata</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Issue (Rural)</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Physicans Memorial Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>THOMAS DOUGLAS SWANN</b> First Middle Last		4. DATE OF DEATH <b>Sept 24 1959</b> Month Day Year	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 27, 1883</b>
9. AGE (In years lost birthday) <b>76</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer (Retired)</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Farm</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>James Ross Swann</b>		14. MOTHER'S MAIDEN NAME <b>Cecelia Herbert</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>None</b>	
INFORMANT Address <b>Mrs. Annie L. Swann (Wife), Issue, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>527.1</b> DUE TO <b>acute cardiac dilatation</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Cor Pulmonale</b> (c) <b>Emphysema (pulmonary)</b> INTERVAL BETWEEN ONSET AND DEATH <b>10 min</b> <b>5 years</b> <b>10 years</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Aug</b> , 19 <b>56</b> , to <b>Sept 24</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>Sept 24</b> , 19 <b>59</b> , and that death occurred at <b>7:05 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>La Plata, Md</b> DATE SIGNED <b>9-24-59</b> ACTUAL SIGNATURE <b>For Johnson</b> M.D. PHYSICIAN'S NAME (Type) <b>For Johnson</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>9/28/1959</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Holy Ghost Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Issue, Charles Co., Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Arthur S. Thane</b> ADDRESS <b>AREHART FUNERAL HOME, INC., La Plata, Md.</b>		24a. REC'D BY REGISTRAR <b>SEP 29 '59</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thane</b>

1

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the urban papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

Blank certificate form with faint horizontal lines for text entry.



10192

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Charles</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Charles</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Indian Head Md</u>				c. LENGTH OF STAY IN 1b <u>7-Yrs.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>138-Circle Pot.Hts Indian Head Md</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>Evermont (one) Whitman</u>				4. DATE OF DEATH <u>9-19-59</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>W-US</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4-2-1887</u>	
9. AGE (In years lost birthday) yrs. <u>72</u>		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Engineer-Railroad</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Transportation</u>		11. BIRTHPLACE (State or foreign country) <u>Kentucky-District-West Virginia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Holly Jackson Whitman</u>				14. MOTHER'S MAIDEN NAME <u>Amanda Cottle</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>UNKNOWN</u>			
17. INFORMANT <u>Pauline Tedrick (Daughter)</u>				Address <u>Oxon Hill Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arterio Sclerosis</u> DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <u>1-Hour</u> <u>Indefinite</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>9-1-58</u> , 19____, to <u>9-19-59</u> , 19____, that I last saw the deceased alive on <u>9-19-59</u> , 19____, and that death occurred at <u>8:30P</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE _____ M.D. <u>Indian Head Md</u> <u>9-19-59</u> PHYSICIAN'S NAME (Type) <u>James E. Andrews, Indian Head Md.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9-23-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Hill Crest</u>		22d. LOCATION (City, town, or county) (State) <u>Cumberland Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Archie Mc La Plata Md</u>				24a. REC'D BY REGISTRAR DATE <u>SEP 29 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur J. Evans</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

